New Jersey Department of Children and Families Policy Manual

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HIV Assessment and Referral for Testing 11-20-2001

If a child's background history indicates behaviors and/or family history which place the child at risk of HIV infection, the Worker, in consultation with the Supervisor and the Child Health Unit, makes a decision regarding the need to test the child for HIV infection. Testing of adolescents should be done with the informed consent of the adolescent and in conjunction with counseling and education.

Children infected with HIV have special care needs even before they become symptomatic which can be addressed only if they are identified. Further, knowing whether an individual has HIV infection may be crucial to preventing the possible spread of HIV to others.

The importance of consistent and appropriate HIV assessment and referral for testing by the child welfare practitioner cannot be overemphasized. Knowing whether a child, adolescent, or adult has HIV infection can be the key to potentially life-saving and life-enhancing treatment, such as treatment to prevent HIV-related complications and treatment to weaken or slow down the progression of the virus.

Pneumocystis carinii pneumonia (PCP) is a major life-threatening HIV complication in children during the first year of life. Prevention of PCP is possible for infants prenatally exposed to HIV with early identification and appropriate medical treatment and medication.

Appropriate treatment of infants exposed to HIV requires identification as soon as possible. This can best be accomplished through the identification of women before or during pregnancy who have HIV infection. Universal HIV counseling and voluntary HIV testing with consent are recommended as the standard of care for all pregnant women in the United States by the Public Health Services (PHS), the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.

N.J.A.C. 8:61-3.1 requires health care providers to provide counseling on HIV infection and offer testing for HIV infection to all pregnant women in their care. The patient must be asked to sign a form acknowledging she received the required counseling and

indicating her preference regarding testing. Test results need to be shared with her by the health care provider and services offered to her.

Early identification of children and families who have HIV infection is the key to life-saving care. Early identification can also lead to prevention education and decrease further HIV transmission. Therefore, a health assessment, which includes an assessment of possible HIV exposure, should be a routine part of initial response for all families referred to the child welfare system.

During the initial response or as part of an ongoing investigation, information is collected from the mother, and whenever possible the father, regarding their health and social/recreational life. On a case-by-case basis this information can assist the Worker in evaluating the possible HIV status of the mother or father, and determine whether the child should be referred for HIV testing.

HIV is transmitted through specific behaviors which all persons should know. These behaviors include the following:

- Unprotected vaginal, anal, or oral intercourse with a person who has HIV infection;

- Children can become infected with HIV from being sexually abused;

- Contact with HIV contaminated blood;

- Sharing of needles, toothbrushes, and razors are possible ways of having contact with blood;

- Receiving blood products (i.e., transfusions, factor concentrates), or tissue or organ transplants from an unscreened donor between January 1,1978 and June 1, 1985;

- Prenatal transmission. A woman who is infected with HIV can give HIV to her baby during pregnancy or at the time of delivery;

- Pregnancy means that there was unprotected sex and hence the possibility of HIV infection.

- Breast-feeding. Since HIV is found in breast milk, a woman with HIV infection can transmit HIV to her infant while breast-feeding.

When assessing a family for possible HIV exposure, if it is not possible to determine whether any of the above modes of transmission or behaviors have taken place, other factors to consider include:

- An infant with a positive toxicology screen;

- Mother with a history of physical evidence of substance abuse, including cocaine, opiates, amphetamines, or PCP. Although sharing needles is the most direct way that drug use spreads HIV, use of drugs such as "crack" or alcohol, can make a person more likely to engage in other high risk behavior such as unprotected sex or trading sex for drugs. Therefore, any history of substance abuse is a reason to do an HIV assessment.

- Maternal or infant history of sexually transmitted diseases (STDs): gonorrhea, syphilis, Chlamydia;

- History of having a male sex partner who also had sex with men;

- Has previously given birth to or fathered children prenatally exposed to HIV; When any of these behaviors or other factors are present, referral for HIV testing and confirmation of HIV status is critical. Referral for HIV assessment and management should be made to a recognized Pediatric HIV Treatment Center after discussion with and agreement of the family. When the HIV status is positive, follow-up after referral includes further HIV testing, medical assessments, and prevention education.

Infants Perinatally Exposed to HIV Infection and Children Infected with HIV
11-4-2013

I. Newborns to Children Aged 18 Months

Since any woman of child-bearing age who is sexually active is at risk of becoming infected with HIV, it follows that any infant born to women whose HIV status is unknown is potentially at risk of becoming perinatally exposed to HIV. Accordingly, whenever possible, it is critical to ascertain the HIV status of a newborn's mother from testing done immediately prior to delivery. The following factors place newborns at even greater risk of exposure to HIV perinatally:

- Infants born to women whose HIV status is unknown;

- All infants born of substance-abusing mothers;

- Infants born with sexually transmitted diseases (STDs), (e.g., syphilis, gonorrhea, chlamydia);

- Infants born to mothers with HIV infection.

All infants born to mothers infected with HIV will test HIV positive at birth due to the presence of the mother's antibodies in their blood. In these cases, more advanced diagnostic testing is indicated. For example, recognized Pediatric HIV Treatment Centers have the capability of identifying through DNA testing the virus and conduct such tests when the infant is born. For CP&P purposes, the infant does not have to be

antibody tested at birth if it can be documented that the mother has HIV infection or other siblings were born exposed to HIV infection perinatally.

Although infants exposed to HIV perinatally may seem healthy at birth, there is less than a 25 percent chance that they will become infected with HIV. Antiretroviral therapy taken during pregnancy, labor, and delivery and given to the baby for 6 weeks postpartum, dramatically decreases the transmission of HIV from mother to baby to approximately 8 per cent. In addition to routine primary pediatric care all infants exposed to HIV will require medical surveillance up to age 18 months by a specialist at a recognized Pediatric HIV Treatment Center where aggressive, early life-saving medical interventions are available.

Each referral of a newborn which alleges HIV exposure and a parental decision to decline medical treatment to interrupt perinatal transmission is assessed to determine the risk of harm or other circumstances which may warrant CP&P involvement. The purpose of the assessment is to:

- Gather information from the treating physician regarding the course of treatment, including whether the proposed course of treatment is necessary and whether adequate alternatives exist;

- Gather information from the parent, including the reasons for the parental decision and whether the withholding of consent is based on complete information.

The Worker, after gathering the above information, weighs the potential harm to the newborn infant against the potential benefits of the proposed treatment. The worker shall consult with CP&P' medical consultant before reaching a decision.

According to the Center for Disease Control (CDC) Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection, children exposed to HIV who repeatedly have negative virologic assays (DNA PCR tests) at birth and at age 1 - 2 months should be retested again at age 3 - 6 months. HIV infection is diagnosed by two positive HIV virologic tests performed on separate blood samples. HIV infections can be reasonably excluded among children who have two or more negative virologic tests, two of which are performed at or beyond 1 month, and one of those being performed at or beyond 4 months. Two or more negative HIV immunoglobulin G (IgG) antibody tests (ELISA/Western Blot tests) performed at an age greater than 6 months with an interval of at least 1 month between the tests also can be used to reasonably exclude HIV infection among children with no clinical evidence of HIV infection. HIV infection can be definitively excluded if HIV IgG antibody is negative in the absence of hypogammaglobulinemia at age 18 months and if the child has both no clinical symptoms of HIV infection and negative HIV virologic assays.

Children who by age 18 months have had two negative ELISA/Western Blot antibody tests, have normal T-cells, and have had all HIV-related medications discontinued

should continue to receive HIV care at a recognized Pediatric HIV Treatment Center until otherwise determined by an HIV specialist.

II. Children up to age 18

The following factors indicate a need for further HIV assessment and testing, if the child is or has:

- Been sexually active;
- No history available - e.g., abandoned infant;
- History of sexual abuse or victimization;
- Symptoms of drug effects or positive toxicology screen for drugs, neonatal or otherwise, including cocaine, opiates, amphetamines and PCP;
- Signs and symptoms consistent with HIV infection or AIDS (e.g., chronic pneumonia, recurrent infections, chronic diarrhea, failure to thrive, developmental delay, enlarged liver, spleen, oral candidiasis after 2 months of age, enlarged generalized lymph glands, or unusual neurologic symptoms);
- received blood products (e.g., transfusion, factor concentrates), or tissue or organ transplant from an unscreened donor between January 1,1978 and June 1,1985.

III. Sexually Abused Children and Adolescents

Because it takes time for HIV antibodies to develop and be visible, it is recommended that HIV testing and periodic retesting be done on children and adolescents who have been identified as having experienced sexual abuse, regardless of the known or unknown HIV status of the perpetrator, or whether the perpetrator is known or unknown. Frequency of retesting is determined by the medical professionals managing the health care of the child/adolescent.

Agency Authority to Consent to Screening for HIV Infection 2-6-2006

Pursuant to N.J.S.A. 30:4C-27, CP&P has the statutory right to consent to medical testing and treatment for children being placed in any agency sponsored out-of-home setting. This includes screening for HIV:

- When the agency has a court order for placement, the agency can consent to screening of children for HIV infection in the absence of parental consent. This authority to consent is applicable to children entering placement and those already in placement.

It is sound casework practice to inform parents that testing for infectious diseases, including HIV infection, will be pursued by the agency as part of a child's pre-placement physical, when family history information indicates the need for an HIV assessment. Informing a parent of this practice allows the agency to elicit the parent's agreement with the practice. In the absence of parental agreement, however, the agency, upon obtaining a court order for placement, has the authority to consent to HIV screening for the child entering placement.

If the parent objects to HIV screening of his or her child in out-of-home placement or entering placement, either verbally or in writing, then CP&P must obtain a court order when family history information indicates the need for an HIV assessment.

Before placing a child out of home, CP&P may request screening for HIV, if there is no prior documentation of HIV testing, when family history information indicates the need for an HIV assessment. A court order for placement is needed pursuant to N.J.S.A. 30:4C-27, which includes authority for CP&P to consent to medical testing and treatment. Whenever possible, testing should be done prior to placement. Hospitals should be made aware that for children entering placement by court order, CP&P has the authority to consent to HIV testing; protocol should be established locally with hospitals to address this issue.

- Consent for HIV screening for children living in their own homes must be obtained from the parent or legal guardian. The CP&P Worker can play a primary role in informing the parent or legal guardian of the importance of screening for HIV for the child, and refer family members to a state designated HIV testing and counseling site.

- If a hospital refuses to test a child, the CP&P Pediatric Nurse Consultant or the Local Office Manager should be contacted immediately.

Related Cites

N.J.S.A. 30:4C-27